Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MICHAEL E TYLER, MD
3100 TIMMONS LANE, STE 250
HOUSTON, TX 77027

Respondent Name

LIBERTY INSURANCE CORP

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-12-0698-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER FAILED TO PROPERLY PAY THIS DESIGNATED DOCTORS CLAIM EVEN AFTER THE CLAIM WAS SENT BACK TO CARRIER AS REQUEST FOR RECONSIDERATION"

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dr. Tyler is seeking additional reimbursement for procedure code 99456/W5/WP/RM for 5 units. However, in accordance with page 11 Rule 134.202, "the examining doctor may bill for a maximum of three (3) body areas. Upon further review we have determined that no additional reimbursement is warranted."

Response Submitted by: Liberty Mutual, 303 Jesse Jewell Parkway, P.O. BOX 4223 Gainesville, GA 30503

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 19, 2011	99456-W5-WP	$300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated September 23, 2011
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.

   Explanation of benefits dated October 11, 2011
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - X598 – CLAIM HAS BEEN RE-EVALUATED BASED ON ADDITIONAL DOCUMENTATION SUBMITTED; NO ADDITIONAL PAYMENT DUE.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor submitted a billing for a DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR) services for 5 body area/unit in box 24G of the CMS-1500 for $1,250.00 and billed with CPT code 99456-W5-WP. Review of the documentation supports that MMI was assigned and per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. The right thumb/fingers and bilateral shoulders (upper extremity), left knee (lower extremity), thoracic (spinal), right leg contusion, and left clavicle fracture, as well as a head contusion are the areas rated. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) Category I method on the thoracic (spinal region) is $150.00. Documentation supports a Range of Motion (ROM) IR method on the bilateral shoulders and right thumb fingers (upper extremities) for a MAR of $300.00 per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a) and $150.00 for the ROM IR to the left knee (lower extremities) per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(b). The narrative mentions performance of IR per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for the three non musculoskeletal conditions of right leg contusion, head contusion, and left clavicle fracture but documentation does not support any examination to these areas and no reimbursement is due. The combined MAR for the MMI and IR exams performed is $950.00.
2. The respondent has already reimbursed the amount of $950.00 for the disputed CPT code 99456-W5-WP. Therefore, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 28, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.